Medical History

Name:________________________________ DOB:________________ Date:___________ Acct #:___________

Purpose of Visit

Chief Complaint:____________________________________ Who referred you to us: ____________________

When did it start:___________________________________ Frequency of complaint :___________________

Where is it located:__________________________________ How long does it last:______________________

How did it start:____

Does anything help or worsen it?____

Any other observations:____

Prior Treatment(s)

When were you last seen for this:_____________________ By whom:_________________________________

What was done:____

Do you use glasses or contacts:______________ For what:____

Any history of eye disease, injury, surgery, disease or prior vision training: ____________________________

____

Any family history of eye problems other than glasses:____

Last eye examination: _____________________ Eye doctor:_______________________________________

Primary care doctor:_________________________________ Location:_________________________________

Medical Conditions

Condition	Current	Personal History	Family History	None	Condition	Current	Personal History	Family History	None
Cardiovascular	☐	☐	☐	☐	Gastrointestinal	☐	☐	☐	☐
Ear, nose or throat	☐	☐	☐	☐	Neurological	☐	☐	☐	☐
Muscle, bone or joint	☐	☐	☐	☐	Psychiatric/Emotional	☐	☐	☐	☐
Allergic, Immune	☐	☐	☐	☐	Blood/Lymph	☐	☐	☐	☐
Genital, Kidney, Bladder	☐	☐	☐	☐	Skin	☐	☐	☐	☐
Respiratory	☐	☐	☐	☐	General/Constitutional	☐	☐	☐	☐
Head Trauma/Stroke	☐	☐ When:___________			Learning Problems/ADHD	☐	☐	☐	☐

Specific information about the above:____

Any general or drug allergies:____

Current medications:____